PDBP
Parkinson's Disease Biomarkers Program

Rapid Eye Movement Behavior Disorder Questionnaire

* Required fields

*Name of Site: _____

*Type of Visit: _____

e.g. Screening, Baseline, 6 months, 12 months, 18 months, 24 months, 30 months, 36 months, 42 months, 48 months, 54 months, 60 months.

*Date of Visit: _____

*GUID: _____

*Age of Subject (years and months): _____

Subject ID: _____

Rapid Eye Movement Behavior Disorder Questionnaire For Informant (Bed Partner) (Mayo Questionnaire)	
Interviewee Who was interviewed for this questionnaire ☐ Informant ☐ Subject served as informant If subject is serving as informant, ask "Have you ever done the following or have you been told you have done the following?" Proceed to question #1.	
Do you Live with the subject?	Yes/No
Do you sleep in the same room as the patient?	Yes/No
If ***no***, is it because of his/her sleep behaviors (snores too loud, acts out dreams, etc)	Yes/No
Sleep Questionnaire-Please mark YES if the described event has occurred <u>at least 3 times.</u>	
1. Have you ever seen the patient appear to "act out his/her dreams" while sleeping? (punched or flailed arms in the air, shouted or screamed)	Yes/No

If yes, answer a-e, below.	
a. How many months or years has this been going on?	☐ year(s) ☐ months
b. Has the patient ever been injured from these behaviors (bruises, cuts, broken bones?	Yes/No
c. Has a bedpartner ever been injured from these behaviors (bruises, blows, pulled hair)?	Yes/No/No Bedpartner
d. Has the subject told you about dreams of being chased, attacked or that involve defending himself/herself?	Yes/No/Never told you about dreams
e. If the subject woke up and told you about a dream, did the details of the dream match the movements made while sleeping?	Yes/No/Never told you about dreams
2. Do the subject's legs repeatedly jerk or twitch during sleep (not just when falling asleep)?	Yes/No
3. Does the subject complain of a restless, nervous, tingly, or creepy-crawly feeling in his/her legs that disrupts his/her ability to fall or stay asleep?	Yes/No
If Yes, answer a-b below.	Yes/No
a. Does the subject tell you that these leg sensations decrease when he/she moves them or walks around?	
b. When do these sensations seem to be the worst?	Before 6pm After 6pm
4. Has the subject ever walked around the bedroom or house while asleep?	Yes/No
5. Has the subject ever snorted or choked him/herself awake?	Yes/No
6. Does the subject ever seem to stop breathing during sleep?	Yes/No
If Yes, a. Is the subject currently being treated for this (e.g., CPAP)?	Yes/No

7. Does the subject have leg cramps at night? (e.g., also called a "charlie horse" with intense pain in certain muscles in the leg)?	Yes/no
8. Rate the subject's general level of alertness for the past 3 weeks on a scale from 0 to 10. 0 1 2 3 4 5 6 7 8 9 10 0=Sleep all day 10=Fully and Normally Awake	